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EDITORIAL BOARD
Practicing Health Care Professionals in Many Spheres of Interest

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STOP

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**PLACE YOUR ANSWERS IN THE *PRETEST* COLUMN OF
THE SEPARATE ANSWER SHEET INCLUDED WITH
THIS COURSE BOOKLET.**

**THE TEST QUESTIONS ARE THE SAME FOR BOTH THE
PRETEST AND THE POST-TEST. THE TEST QUESTIONS
ARE FOUND AT THE BACK OF THIS COURSE
BOOKLET.**

AFTER COMPLETING THE PRETEST

THEN

READ THE COURSE

THEN

**TAKE THE POST-TEST FOR CREDIT AND SEE HOW
MUCH YOU HAVE LEARNED.**

**TO GET THE MOST OUT OF THIS GSC HOME STUDY
COURSE USE THE PSQ4R LEARNING SKILLS
TECHNIQUE DESCRIBED ON THE FOLLOWING PAGES.
GOOD LUCK.**

How to get the most out of your GSC Home Study Course using the PSQ4R technique!

Continuing education should provide the licensee with timely information that can be recalled for day to day use. Each GSC Home Study CE Course was planned and produced in accordance with the PSQ4R method described in the following paragraphs. GSC Home Study has found the PSQ4R method useful for retention of new or updated information.

PSQ4R, a method for improving reading comprehension, has been used by dozens of colleges and universities.

P = Purpose

S = Survey

Q = Question

4Rs = Read Selectively, Recite, Reflect, and Review.

1. Determine your **purpose** for reading this course. For many of you it may be merely to obtain continuing education credit to maintain your license. But, take a moment and look beyond this reason, what is it about this particular course topic that interests you? How does it relate to your current practice? (Est. Time— 5 minutes)
2. Test your knowledge of the course subject matter prior to reading the course by answering the course examination questions at the back of the booklet. Use the pretest column of the answer sheet to write your answers. (Est. Time-20 minutes)
3. **Preview** the course by surveying or skimming the course objectives, subject headings, illustrations, graphics and test questions. Pay attention to the first sentences, introductions, conclusions or summaries in the course. Write down any words that are unfamiliar to you. (Est. Time-15 minutes)
4. Make up **questions** using the section headings as a guide. Write the questions on a blank sheet of paper and leave space for your answers (2-3 inches). For example, if the section heading states "Diagnosis of Alzheimer's Disease", write the question "What are the current criteria used to diagnose Alzheimer's disease?" leaving space for the answer later on. (Est. Time-15 minutes)
5. **Read selectively** to find the answers to your "section-heading" questions. Write your answers in the space you provided. Be sure to write down and/or look up any words that are or were unfamiliar to you. Also, as you continue to read don't forget to look for ideas and information that are in alignment with your purpose for taking the course. (Est. Time- 80 minutes)
6. **Recite** the answers to your questions, by reading the question aloud with the answer covered up. Use your own words as much as possible. If you don't recall the answers, look over that section again. (Est. Time-5 minutes)

7. **Reflect** on the information in the section you've just read. Try to make a simple outline, table, flow diagram or "doodle". (Est. Time-5 minutes)
8. **Review** "section-heading" questions and answers, diagrams and outlines. (Est. Time- 20 minutes)
9. Take the Course Examination. Place your answers on the detached answer sheet posttest column inserted with your course packet. (Est. Time-30 minutes)

Normal Estimated Time to Complete this GSC Home Study CE Course Activity

Taking pretest	20	minutes
Reading course	90	minutes
Taking posttest	30	minutes
Re-reading course to locate answers	40	minutes
TOTAL time	180	minutes

Estimated Time to Complete this GSC Home Study CE Course Activity Using the PSQ4R Method for Improving Your Reading Comprehension

Determine the Purpose for taking the course	5	minutes
Take the pretest	20	minutes
Preview the course	15	minutes
Make up Questions	15	minutes
Read Selectively	80	minutes
Recite the answers to your questions	5	minutes
Reflect the information you just read in the course	5	minutes
Review questions, diagrams, and outlines	20	minutes
Take the posttest	30	minutes
TOTAL time using the PSQ4R method	195	minutes

Use the method you think will be the better use of your time.

OBJECTIVES

At the successful completion of this course, the student shall be able to:

- Identify gender differences associated with mental illness.
- Describe the components of a psychiatric assessment of a female client.
- Identify the symptoms, diagnostic determinants and treatment methods for the major mental health disorders affecting women.
- Distinguish between the major treatment strategies used in mental health disorders.
- Describe the common side effects and major types of drug interactions associated with the use of antidepressants.
- Identify the diagnostic criteria for depression.
- Outline the biologic theory of depression.
- Distinguish between tricyclic antidepressants, monoamine oxidase inhibitors, selective serotonin reuptake inhibitors and atypical antidepressants.
- Identify statistical risks for suicide associated with women.
- Describe the symptoms and risk factors associated with bipolar disorder.
- Outline a plan of care for a woman with premenstrual disorder.
- Identify self help strategies for the management and treatment of mental health disorders including stress management, diet, exercise, promotion of self esteem, rest and anger management.
- Identify resources available to women on the subject of mental health.

Primary contributions by:

Anne F. Cruse, RN
Santa Fe, NM

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INTRODUCTION

Gender Differences in Psychiatric Disorders

In a comparison of the sexes, women take the statistical lead in a variety of mental health disorders. The question is, why? Research points its finger at a variety of factors including both psychosocial and physical causes. The dance that continuously goes on between mind and body makes it difficult to pinpoint the exact beginnings of psychiatric mayhem. Does brain chemistry alter the way we look at life, or does the way we look at life alter brain chemistry? There is no simple and predictable sequence of events in mental illness. It is known that such factors as social status and expectations, lower wages, and increased vulnerability to sexual and domestic violence predispose the female to certain mental disorders. In addition, research is increasingly showing that gender differences exist in brain anatomy and that the male and female reproductive hormones have different and identifiable psychoactive effects.

The following chart summarizes the lifetime incidence of the most common mental health disorders in both men and women in the total population.

Disorder	Women	Men
Depression	21.3	12.7
Bipolar Disorder (manic-depressive)	1.4	1.1
Seasonal Affective Disorder	6.3	1.0
Panic Disorder	5.0	2.0
Social Phobia	15.5	11.1
Generalized Anxiety Disorder	6.6	3.6
Schizophrenia	1.7	1.2
Alcohol Dependence	8.2	20.1
Alcohol Abuse Without Dependence	6.4	12.5
Anorexia Nervosa	0.5	0.05
Bulimia	1.1	0.1
Antisocial Personality	1.2	5.8

(ref: Burt and Hendrick, 1997)

Women have an almost two fold risk of depression in comparison to men. They also have an increased incidence of anxiety, eating and seasonal affective disorders.

The Psychiatric Assessment of Women

The first step in the care of women with mental disorders is a careful assessment. This should include a history of the presenting symptoms, careful evaluation of precipitating factors including other physical conditions and hormonal variables, a family history of mental illness, and review of diet, exercise, medications, alcohol and drug use.

The following assessment tool provides an example of some of the considerations which should be included when evaluating a woman's mental health profile.

Component	Considerations
History of present illness	Characterize symptoms in relation to: • phase of menstrual cycle • use of hormonal contraception supplements • pregnancy • postpartum period • breast feeding/weaning • abortion • infertility treatment • hysterectomy • perimenopause
Medications	Include hormone therapy: contraceptives, replacement therapy, fertility medications. Include all prescribed and over the counter (OTC) medications.
Diet	Rule out ritualistic or restrictive eating patterns, bingeing, self induced vomiting, use of diet pills, laxatives, emetics, diuretics.
Alcohol and drugs	Screen for covert use, assess habits.
Family psychiatric history	Include history in female family members of premenstrual syndrome, postpartum mood disorders and depression. Check for family history of schizophrenia.
Medical history	Rule out autoimmune illnesses (lupus, thyroid, fibromyalgia) that may present with psychiatric symptoms. Rule out history of sexually transmitted disease that may affect sexual and childbearing capacity.
Menstrual history	Rule out pregnancy, menstruation related symptoms (bloating, weight gain, cramping, breast tenderness), perimenopausal symptoms (irregular periods, hot flashes etc.).
Social, developmental history	Note sexual preference, relationship styles and satisfaction with current relationship. Note current or past sexual, physical or emotional abuse. Assess support systems.
Socioeconomic status	Assess level of economic support and ability to meet ongoing financial needs.
Coping mechanisms	Assess strategies for dealing with stress including problem solving skills, level of physical activity, access to supports, etc.

Distinguishing Between Mental Health Disorders

Mental health disorders often present an array of symptoms which don't like to arrange themselves in a neat order or conform to a 'textbook' profile. Although there is a good deal of overlapping of symptoms and management strategies, common mental health disorders may be distinguished from each other as follows:

Disorder	Symptoms	Diagnosis	Treatment
Depression	Sad, anxious, irritable, hopeless, pessimistic, guilty, worthless, helpless, loss of interest in activities, appetite or weight change, sleep problems, fatigue, loss of energy, inability to concentrate or make a decision, suicidal thoughts, persistent aches and pains	Thorough medical and psychiatric evaluation, neurological exam, thyroid screen, anemia screen, evaluation for family history of depression, review of alcohol, drug habits	Medication including antidepressants and or psychotherapy. Severe cases may warrant hospitalization.
Seasonal Affective Disorder	Depression that affects the individual each year during fall and winter. Women are 4 times more likely to experience this than men. Symptoms include sadness, fatigue, poor concentration and withdrawal along with other symptoms of depression.	Diagnosis is generally made based on the pattern of depression.	Treatment includes daily light treatment under the guidance of a psychiatrist. Antidepressants (serotonin reuptake inhibitors such as fluoxetine) may be prescribed.
Manic Depressive Illness (bipolar disorder)	Periods of elation, hyperactivity, euphoria or irritability alternating with a depressive phase which is characterized by feelings of hopelessness and indifference	Comprehensive physical and mental evaluation including a neurological exam	Medical management is centered on the use of lithium. Psychotherapy may be used as an adjunctive treatment.
Anxiety Disorder	Generalized anxiety and worry most of the time, in severe cases may interfere with the ability to perform ordinary daily tasks. Usually occurs gradually during childhood or adolescence. More common in women. Genetic predisposition. Symptoms diminish with age.	History reveals state of excessive anxiety for a period of at least 6 months. Medical and psychiatric evaluation, review of meds, alcohol use, screening for hyperthyroidism.	Medication management typically includes benzodiazepines or anti-anxiety medication. Psychotherapy, behavior modification and relaxation techniques often helpful.

Disorder	Symptoms	Diagnosis	Treatment
Panic disorder	Brief periods of intense fear accompanied by physical symptoms such as a pounding heart, chest pains, dizziness. May demonstrate irrational fears and phobias. More common in women, family history increases risk. Panic attack may happen at any time, accompanied by fear of losing control. May be triggered by stress, loss, excessive use of caffeine or stimulants. Often occurs in people who are agoraphobic (fear of public places or situations).	Physical and psychiatric exam, family history, rule out hyperthyroidism, epilepsy, heartbeat abnormalities.	Psychotherapy, including cognitive behavioral therapy, use of medications including antidepressants and anti-anxiety drugs.
Phobias	Sudden, uncontrollable and irrational fear when exposed to a particular situation or object (insects, heights, water, flying, enclosed spaces, public speaking, blood or injury etc.)	Medical and psychiatric history and exam. Rule out underlying or coexisting depression.	Generally treated with cognitive behavioral therapy, medication or a combination of the two. In some instances anti-anxiety medications may be used.
Post Traumatic Stress Disorder	Follows a terrifying event such as rape, involves intense fear, helplessness and horror, characterized by recurring memories of the event, withdrawal and emotional numbness. Affects more women than men. Occurs at any age. May be accompanied by abuse of alcohol, drugs. High risk of suicide. Symptoms generally occur within 3 months of the event.	Includes history of the traumatic event and symptoms or feelings that have arisen as a result.	Individual and or group therapy are recommended. Medication may help control some of the related symptoms and may include antidepressants or anti-anxiety medications.
Sleep Disorders	<i>Insomnia:</i> Inability to fall asleep within 30 minutes of going to bed, frequent waking during the night, inability to sleep for more than 5 hours a night.	Diagnosis includes a careful review of symptoms and related factors such as stress or physical conditions. Sleep history is obtained. Conditions to rule out include hormonal imbalances, hyperthyroidism, depression, incontinence, pain or diabetes.	Treatment is targeted at the cause of the sleep disorder. It typically includes a sleep 'diary'. Relaxation tips, exercise, avoidance of stimulants are all explained. Sleeping pills may be used for brief periods but are not considered a good long term option.

Disorder	Symptoms	Diagnosis	Treatment
	<i>Narcolepsy:</i> excessive daytime sleepiness, sleep may include vivid dreams or hallucinations and short episodes of muscle weakness causing them to fall.		<i>Narcolepsy</i> may be treated by addressing any underlying cause. Medications to increase alertness throughout the day may be used along with antidepressants if depression is a factor.
Eating Disorders	<i>Bulimia:</i> binge eating followed by forcible purging (vomiting, laxatives, diuretics, enemas). <i>Anorexia:</i> self induced starvation with loss of 15% or more of body weight. Both eating disorders may be accompanied by abnormal interest in food, eating rituals, obsessive exercise, depression, problems with self image.	Diagnosis is made based on symptoms, a complete medical and psychiatric evaluation and lab testing to rule out other illnesses, dehydration, malnutrition and chemical imbalances.	A team approach to eating disorders involves a medical doctor, nutritionist and psychotherapist. The focus is on resolving the issues that triggered the eating disorder including depression, anxiety, problems with self esteem. Family therapy may be an important part of treatment. Group therapy is sometimes indicated. Hospitalization may be required when weight loss is severe.
Schizophrenia	Complex, poorly understood condition characterized by disordered thinking, abnormal perception of reality, hallucinations, delusions, inappropriate emotional responses or abnormal behavior. In women, first symptoms usually appear in 20s or early 30s. Family history increases risk. Symptoms may be preceded by isolation or withdrawal, unusual speech or behavior. Behavior may include detachment, agitated or violent, inappropriate emotional responses.	Conditions to rule out include abuse of alcohol or drugs, physical head trauma or brain tumor, mood disorder, severe emotional trauma. A complete physical and psychiatric exam and history should be obtained including a review of the family history.	Treatment options vary according to the severity of the disorder but generally require long term intervention. Antipsychotic medications can partially correct chemical imbalances in the brain reducing hallucinations and delusions. Individual and group therapy may be used as an adjunct.

Disorder	Symptoms	Diagnosis	Treatment
Delusional Disorder	Individual experiences false beliefs that are not subject to reason in which something is happening to them that is not actually occurring... may include paranoia (excessive, irrational suspiciousness) or extreme jealousy. Symptoms may interfere with ability to function normally in work or social situations. Delusions may trigger anger, violence or disruptive behavior.	A psychotherapist will attempt to distinguish truth from delusion and will screen for other psychological disorders. Physical symptoms should be evaluated medically.	Treatment combines medication and psychotherapy. Antipsychotic drugs may be helpful.

Treatment Strategies in Mental Health Disorders

Management of a serious mental health disorder often depends on the use of psychotherapy and or drug therapy. Non pharmacological interventions such as relaxation, diet, exercise and education should also be part of the mental health package. Some of the major interventions can be summarized as follows.

1. *Cognitive Behavior Therapy*

Cognitive behavior therapy is a form of psychotherapy based on the belief that thought patterns can lead to depression. A therapist can assist in learning to recognize negative thought patterns and behaviors and replace them with positive ones. This form of therapy is usually short term, highly focused and goal oriented.

2. *Psychotherapy*

Psychotherapy, also called 'talk therapy', involves meeting regularly with a trained, qualified therapist to discuss all aspects of emotional and behavioral problems and learning how to make positive changes in life. Like antidepressant medications, psychotherapy can relieve depression by altering the balance of neurotransmitters - chemical messengers in the brain that influence mood, concentration, sleep, energy and appetite. Interpersonal psychotherapy may be used for difficulties in relationships, the goal being to deal more effectively with others.

3. *Drug Therapy*

There are several large categories of drugs used in the treatment of mental health disorders. Among these are sedatives and hypnotics, antianxiety drugs, antipsychotics and

antidepressants. Hormonal conditions may also be treated with hormone replacement therapy. When prescribing these medications it is extremely important to screen for other physical conditions including pregnancy, and OTC drug use.

The Agency for Health Care Policy and Research (AHCPR) provides the following reference for the use of antidepressant drugs. It is important to note that almost all of them need to be evaluated for common side effects and high risk drug interactions.

The Antidepressant Pharmacopeia

Drug	Common Side Effects							Dangerous Drug Interaction
	Anticholinergic	Drowsiness	Insomnia/agitation	Orthostatic hypotension	Cardiac arrhythmia	GI distress	Weight gain	
Amitriptyline	4+	4+	0	4+	3+	0	4+	Antiarrhythmics, MAIOs
Desipramine	1+	1+	1+	2+	2+	0	1+	Antiarrhythmics, MAIOs
Doxepin	3+	4+	0	2+	2+	0	3+	Antiarrhythmics, MAIOs
Imipramine	3+	3+	1+	4+	3+	1+	3+	Antiarrhythmics, MAIOs
Nortriptyline	1+	1+	0	2+	2+	0	1+	Antiarrhythmics, MAIOs
Protriptyline	2+	1+	1+	2+	2+	0	0	Antiarrhythmics, MAIOs
Trimipramine	1+	4+	0	2+	2+	0	3+	Antiarrhythmics, MAIOs
Amoxapine	2+	2+	2+	2+	3+	0	1+	MAIOs
Maprotiline	2+	4+	0	0	1+	0	2+	MAIOs
Trazodone	0	4+	0	1+	1+	1+	1+	----
Bupropion	0	0	2+	0	1+	1+	0	MAIOs possibly
Fluoxetine (Prozac)	0	0	2+	0	0	3+	0	MAIOs
Paroxetine	0	0	2+	0	0	3+	0	MAIOs
Sertraline (Zoloft)	0	0	2+	0	0	3+	0	MAIOs
Monoamine oxidase inhibitors (MAOIs)	1+	1+	2+	2+	0	1+	2+	Vasoconstrictors, decongestants, meperidine, possibly other narcotics

0 = absent or rare 2+ = in between 4+ = common

*anticholinergic effects: dry mouth, blurred vision, urinary hesitancy, constipation

ref: AHCPR Pub. No. 93-0552/ Depression in Primary Care

A Closer Look at Women and Depression

Depression affects more than 11 million people in the United States each year. Episodes are often of long duration with a 50% rate of recurrence. *Women are affected almost twice as often as men.* Depressive disease occurs across a continuum from mild, transient feelings of sadness to the severe, pervasive sense of helplessness and hopelessness that is characteristic of manic depressive illness. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) of the American Psychiatric Association, diagnosis is based on the following:

- 2 weeks of depressed mood or loss of interest in pleasure and activities
- at least 5 other symptoms including:
 - loss of appetite
 - insomnia or hypersomnia
 - psychomotor agitation or retardation
 - fatigue or loss of energy
 - feelings of worthlessness or guilt
 - a diminished ability to think and concentrate
 - recurrent suicidal thoughts.

What Causes Depression?

Depression may be a factor of genetics, environment, hormones, and or body chemistry . It is an illness which is both treatable and in most cases curable. Understanding the biological premise for depression is useful in understanding treatment strategies.

The *biologic theory* of depression explains the role of neurotransmitters in maintaining normal brain functioning. Neurotransmitters are chemical messengers which function to transmit nerve impulses from neuron to neuron. These chemicals are produced in the brain and help control functions such as sleep, arousal, appetite and pleasure responses. The neurotransmitters are divided into several categories. One of these categories, the monoamines, is implicated in depression. These monoamine neurotransmitters include dopamine, norepinephrine, epinephrine, serotonin, acetylcholine and histamine. The biogenic amine theory of depression proposes that a deficiency of the neurotransmitters norepinephrine and serotonin contributes to the mood disorder.

How Do You Assess for Depression?

In addition to screening for the diagnostic symptoms noted earlier, the following questions are useful in making an assessment of depression:

Can you describe your mood for me?

How long have you felt this way?

What is the feeling of depression like for you?

Have you noticed changes in your level of interest in normal activities?

How would you rate your feelings of depression on a scale of 1-10?

How do you explain your depression?

Have you experienced any losses or changes in your life?

If you could change one thing, what would it be?

Are you experiencing thoughts of suicide?

Do you have a plan for suicide?

How would you go about it?

Interventions in Managing Depression

Antidepressant drug therapy is the mainstay of treatment for depression and is helpful in 65-75% of cases. Antidepressants work to increase the amount of neurotransmitters, specifically norepinephrine and serotonin available at the synapse. There are four major categories of antidepressants, each of which accomplishes this objective in slightly different ways.

1. *Tricyclic antidepressants (TCAs)* act by blocking reuptake of neurotransmitters at the presynaptic neuron. They affect more than one neurotransmitter and are nonselective in action. As a result, both serotonin and norepinephrine remain in the synapse rather than being reabsorbed for recycling. The effects of TCAs include elevated mood, increased activity levels, appetite stimulation. Sleep patterns may be normalized. Maximum effect occurs in 2 to 4 weeks, therefore it is important to encourage use for at least four weeks prior to evaluating effectiveness. Adverse effects of the TCAs are sedation, dry mouth, blurred vision, urinary retention, constipation, worsening of glaucoma and benign prostatic hypertrophy. In addition, they have quinidine like effects on the heart and cardiovascular

system. This necessitates a baseline EKG prior to treatment. Elderly patients and those who have cardiac histories are usually not candidates for TCA therapy.

2. *Monoamine oxidase inhibitors (MAOIs)* are the oldest of the antidepressants. They are still used, especially when other drug therapies are ineffective. They act by inhibiting the enzyme monoamine oxidase which is responsible for metabolizing norepinephrine and serotonin. When the enzyme is inhibited, increased amounts of neurotransmitters remain at the synapse and act to elevate mood and stimulate psychomotor activity. The problem with these drugs is that ingestion of the pressor amine, tyramine, present in a variety of foods and beverages, acts with the MAOI to elevate levels of norepinephrine in the blood. Concurrent use of drugs containing sympathomimetic amines, such as OTC decongestants, allergy medications and appetite suppressants also act to elevate norepinephrine blood levels. They may increase to the point of a hypertensive crisis, which may be fatal. Symptoms such as severe occipital headaches, nausea and vomiting, elevated blood pressure, photophobia, dilated pupils and arrhythmias may occur and are indications that the drug should be discontinued immediately.

3. *Selective Serotonin Reuptake Inhibitors (SSRIs)*

These drugs are now the first choice treatment for many patients with depression. They act specifically on the neurotransmitter serotonin, preventing its reuptake. They do not cause cardiovascular side effects and are less likely than the TCAs to cause anticholinergic side effects. They may cause nausea, headache, nervousness and insomnia. They appear to cause a high incidence of anorgasmia and other sexual dysfunction. Again, mood elevation takes up to four weeks of treatment.

4. *Atypical Antidepressants*

Atypical antidepressants including bupropion, nefazodone, and venlafaxine appear to act similarly to the tricyclics and the SSRIs. There is no adverse effect on sexual function. Although their antidepressant effects are not yet well understood, they induce fewer anticholinergic and cardiovascular effects than TCAs. Potential side effects include seizure risk with bupropion, hypotensive effects with nefazodone, and dose related hypertension with venlafaxine.

Although antidepressants have different mechanisms of action depending on the drug class, all function to increase the level of neurotransmitters present in the synapse thereby elevating the patient's mood.

Precautions:

An important consideration for all patients taking antidepressants is a rare but potentially fatal reaction called *serotonin syndrome*. This is a toxic state that may result in severe hyperthermia, altered muscle tone, mental changes including agitation and restlessness, and autonomic changes such as blood pressure fluctuation, tachycardia and diaphoresis. MAOIs should not be administered concurrently with the SSRIs or the TCAs and a reasonable period should be observed when switching from one agent to another...this period varies and can range from seven days to 5 weeks depending on the specific drugs involved.

Therapeutic Interventions for Patients Experiencing Depression

When establishing a care plan for a patient who is experiencing depression, it is important to reflect a positive attitude and to provide information that will foster the patient's recovery and long term management of the disorder.

Intervention	Rationale
Provide positive input regarding the treatable nature of the illness	Hopeful attitude counteracts the negativity common to depression
Encourage daily exercise and activities	Exercise stimulates endorphin release, promoting feelings of well being
Facilitate adequate nutrition: provide small, frequent meals, consider food preferences	Counteracts the anorexia common in depression
Promote sleep by using bedtime relaxation techniques	Insomnia often is a problem with depression & relaxation measures are sleep inducing
Encourage and accept verbalizations of feelings	Communicates acceptance of the person and counteracts isolation, negative self evaluations
Assume the patient will make own decisions	Provides a sense of control and empowerment
Identify realistic goals for changes with patient	Goal achievement provides sense of accomplishment
Encourage positive self statements	Counteracts feelings of negative self evaluation
Evaluate lethality of suicidal thoughts, implementing appropriate suicide precautions	Maintains patient safety
Teach about depression and the antidepressant medications prescribed	Enlists patient as active partner in treatment

Women and Suicide

Tragically, one of the risks associated with depression is suicide. Care of the patient who is depressed should always include careful evaluation for suicide risk. Consider the following:

- About twice as many women as men attempt suicide
- Women are less likely than men to actually kill themselves
- A failed suicide attempt is a cry for help
- Persons attempting suicide need immediate professional help
- The majority of people with depression can be treated successfully
- People who talk about committing suicide *should be taken seriously*, get help immediately (911, suicide hotlines, personal physician etc.)

Manic Depressive Illness (bipolar disorder)

Bipolar disorder is only slightly more common in women, however when it occurs in women it has certain distinguishing characteristics. Women are more prone than men to rapid mood swings and the cycles which occur between manic and depressive states tend to be shorter and more frequent. Women also experience more depression.

Special considerations in treating women with this disorder include:

- symptoms may worsen premenstrually, therefore it is useful to monitor for patterns related to the menstrual cycle.
- lithium treatment is sometimes associated with hypothyroidism in women- thyroid function should be monitored during therapy.
- drug treatment (carbamazepine) may interfere with hormone therapy including contraceptives and hormone replacement. Post menopausal women may need to increase their hormone replacement to prevent hot flashes and menopausal symptoms. When hormones are being used for contraception, another form of contraception should be used.
- medication levels may fluctuate across the menstrual cycle.
- psychotropic agents may produce menstrual cycle disturbances.
- mood stabilizing medications are associated with relatively high rates of fetal anomalies.
- women with bipolar disorder are at significant risk for postpartum psychosis.

Recognizing the Symptoms

The symptoms of manic depressive illness may be broken down into those which characterize the manic phase and those which accompany the depressive stage. They include:

Manic Phase:

- extreme irritability and distractibility
- excessive euphoria or elation
- increased energy, activity or restlessness
- racing thoughts and ideas and rapid speech
- unrealistic belief in your abilities and powers
- a prolonged period of behavior that is different than usual
- uncharacteristically poor judgment
- increased sexual drive
- abuse of drugs
- intrusive obnoxious or provocative behavior
- denial that anything is wrong
- paranoia

Depressive Phase:

- feeling sad or anxious
- feeling hopeless, empty or pessimistic
- feeling guilty, worthless or helpless
- loss of interest in activities, hobbies, friends
- sleep disturbances or insomnia
- change in appetite with weight loss or gain
- decreased energy and fatigue
- thoughts of death or suicide
- restlessness or irritability
- difficulty concentrating, remembering, making decisions
- persistent physical problems - headaches, digestive problems, etc.

Women and Hormones

There are very few women who have escaped the emotional peaks and valleys which accompany hormonal cycles. While men typically have an enviably consistent amount of testosterone circulating in their systems throughout adulthood, women encounter hormonal changes which occur on a daily basis,

influenced by age and the stage of the menstrual cycle. The female hormones make their first big appearance at puberty and continue to direct menstrual cycling until menopause, some 30 odd years later when they taper off. The intent of the body in its manufacture of the female hormones is to prepare the body for conception, pregnancy and lactation, not to drive us nuts.

Premenstrual Syndrome

Premenstrual syndrome, also known as Premenstrual Dysphoric Disorder (PMDD) is sometimes classified with female mental health disorders because of its emotional components. It is a syndrome of recurrent physical and emotional symptoms that occur in the last 7 to 14 days of the menstrual cycle and remit within a day or two following the onset of menstruation. The diagnosis of premenstrual syndrome depends on the presence of 5 or more of the following symptoms:

- depressed mood, feeling of hopelessness, poor self esteem
- anxiety, tension, irritability
- emotional lability, feeling suddenly tearful or sad, crying
- decreased interest in usual activities including friends
- sense of difficulty in concentrating
- lethargy, fatigue, loss of energy
- change in appetite, food cravings, overeating
- hypersomnia or insomnia
- a sense of being out of control
- physical symptoms including breast tenderness, swelling, headaches, joint or muscle pain, bloating, weight gain
- Symptoms typically interfere with personal life, work or school. They occur in at least two consecutive cycles.

Etiology:

The cause of PMS is unclear. Hormones are the culprit, however how they concoct this emotional roller coaster is uncertain. The biological changes of the menstrual cycle probably play a big role because symptoms do not occur in the absence of menstrual cycling (before puberty, during pregnancy, or following menopause). Suggested causes include abnormal levels of estrogen, progesterone, follicle stimulating hormone (FSH), luteinizing hormone (LH), cortisol, dihydrotestosterone, thyroid hormones, endogenous opioids and serotonin.

Risk factors:

Women with a history of postpartum depression and mood changes induced by oral contraceptives appear to be at increased risk for PMS. A history of clinical depression also appears to be a risk factor along with a family history.

Evaluation:

Evaluation should include all of the following:

- Medical history including assessment of endocrine and reproductive disorders
- Psychiatric history including onset, frequency and duration of symptoms, precipitating factors, and family history
- Laboratory workup including a CBC and chem profile including glucose, calcium and magnesium and thyroid function
- Family history with focus on history of premenstrual symptoms, treatment strategies and outcomes
- Medication use including assessment of meds that may produce psychiatric side effects such as antihypertensives, bronchodilators, antiulcer agents, steroids, analgesics, sedatives and decongestants
- Diet and nutritional assessment including use of caffeine, salt, alcohol. Rule out potential deficiencies including vitamin B6, calcium and magnesium.

A differential diagnosis:

It is important to rule out disorders which are sometimes confused with PMS. These include:

- endometriosis
- chronic fatigue syndrome
- migraine
- systemic lupus erythematosus
- irritable bowel syndrome
- epilepsy
- thyroid disorders
- fibrocystic breast disease

Management and treatment:

Management and treatment of PMS must be tailored to the individual symptoms and needs of the patient. It is important to start with a diary of symptoms which should be charted by the patient for several cycles, mapping out the symptom, its severity and where it occurs in the cycle. Once the symptoms and their occurrence within the cycle have been clearly identified, a plan of care can be implemented. This plan of care typically has a nonpharmacological component which may be accompanied by drug treatment.

Nonpharmacological interventions include:

- education and support
- family education
- stress reduction
- diet changes: reduction of salt, caffeine, alcohol
- reduction or discontinuance of nicotine
- cognitive behavioral approaches
- exercise
- relaxation techniques

Pharmacological Interventions:

Generally nonpharmacological interventions are tried first. When symptoms persist, treatment may also include one or more of the following:

- psychotropic drugs to address depression and anxiety
- hormonal therapies including progesterone, estrogen, synthetic androgens, gonadotropin releasing hormone agonists (resulting in anovulation)
- vitamins and minerals including pyridoxine (vitamin B6) which acts in the synthesis of dopamine and serotonin: useful in reduction of depression, irritability, fatigue, edema and headaches at a dose of 50 mg/day
- calcium, magnesium and vitamin E which may reduce premenstrual depression, pain and fatigue
- diuretics for fluid retention and bloating
- prostaglandin inhibitors to reduce pain and swelling (prostaglandins modulate inflammatory responses and increase pain sensitivity)
- other agents: the beta blocker, atenolol may improve premenstrual irritability and the antihypertensive clonidine has shown some results in relieving anxiety, depression, hostility and irritability

Women and Stress

Women do not hold the monopoly on stress, however the manifestations of stress and stress related diseases are on the increase for women. Statistically anxiety disorders and post traumatic stress syndromes are more common in women. The reason for this is not entirely clear. Hormonal changes, social expectations and evolution of roles into the work force have all been suggested as factors.

Causes and Symptoms of Stress

Stresses specific to women:

- a majority of women now combine outside jobs with full responsibility for home and children, feeling pressure to be perfect at all of these
- women earn less in the job force
- many women are single parents; many are poor
- some women are at home all day with small children and socially isolated
- sexual harassment and abuse takes place on the street, in the workplace and at home

recognizing symptoms of stress:

- headaches
- neck, back and shoulder pains
- nervous twitches, 'tics'
- insomnia
- skin rashes
- greater susceptibility to colds, influenza, other illnesses
- worsening of existing conditions or illnesses
- depression, anxiety, irritability, despair
- jaw pains, grinding of teeth
- cancers and cold sores
- stomachaches, diarrhea, loss of or increase in appetite
- increased frequency of herpes episodes

Women and Self Help

Education and lifestyle can go a long way in combatting some of the causes and symptoms of mental health disorders. Women need to know what their resources are and how and when to access them.

They need to maintain both their physical and mental health on a regular basis by practicing such self care habits such as good nutrition, adequate exercise, regular relaxation and stress management. Basic strategies include:

- *Talk about your problems-* get support wherever you can: friends, family, support groups, coworkers; doctor, counselor
- *Eat a healthy diet.* Stress increases your metabolism, raising energy needs. Avoid caffeinated drinks and foods
- *Exercise regularly.* Regular exercise is one of the best ways to reduce stress and increase brain friendly endorphins. Fit it into your daily routine
- *Get plenty of sleep.* Fatigue can reduce your ability to deal with stress.
- *Learn to relax.* Take at least a few minutes every day to sit back, close your eyes, relax your body and clear your mind
- *Set realistic goals.* Being practical about what you can accomplish will avoid frustration, disappointment and guilt.
- *Set priorities.* Concentrate your time and energy on doing essential tasks. Delegate when you can
- *Avoid too many changes at once.* Whenever you can, plan major life events such as changing your job or moving so they do not occur at the same time
- *See your doctor* if the stress in your life becomes overwhelming. Ask him or her to recommend a therapist.

The Mental Health Diet

What, when and how we eat has an enormous impact on how we feel and function. Women must educate themselves about how diet can help them stay physically and mentally fit through all stages of the life cycle, preventing heart disease, cancer, osteoporosis and other illnesses. An unhappy relationship with food, an unsound diet or an obsession with weight predisposes to mental illness.

We are subjected to a barrage of conflicting cultural information about food and weight. The goals of healthy eating are:

- a healthy capacity to self nourish
- an intake of healthy foods for optimal energy and psychological wellbeing

- a properly balanced diet with the nutrients needed to prevent diseases and maintain vigor

To achieve these goals the following basic guidelines should be incorporated:

- a reasonable balance among protein sources, complex carbohydrates, starchy carbohydrates and dairy as set out in the food pyramid
- use of olive and canola oils for cooking, salad dressings, spreads, dips whenever possible
- a low to moderate intake of refined sugars as found in most desserts, muffins, pastries, certain breakfast cereals, ice cream etc.
- salt and sodium in moderation
- caffeine in moderation
- alcohol in moderation

What about Supplements?

It is generally agreed that foods are the best sources of vital nutrients. Certain vitamins and minerals are particularly important for prevention and alleviation of conditions that affect women, and supplementation can sometimes be a sensible adjunct to healthy eating.

Vitamin	Food Sources	Considerations
Vitamin A & Betacarotene	Dark green, yellow and orange fruits and vegetables	Betacarotene is the biological precursor to vitamin A in the body. It is recognized to be a powerful antioxidant, protecting our cells from damage caused by free radicals. A diet rich in these nutrients has been associated with a lower incidence of cancer. <i>Vitamin A supplementation over 10,000 IU has been associated with birth defects.</i>
B Vitamins	Whole grains and cereals, brewers yeast, beans, peas, meats, fish, poultry, liver, eggs and milk products	All of the B vitamins are considered necessary for health and vitality. Women with high estrogen levels may require more B vitamins since the liver needs B vitamins to break down and inactivate estrogen. Women with PMS and women on hormone replacement therapy may require more B vitamins. B6 is considered crucial to maintenance of a healthy immune system but <i>supplements should not exceed 200 mg</i> . Folic acid supplements have slowed precancerous conditions. Folic acid deficiency has been associated with birth defects. 400 mcg of folic acid has been recommended for prevention of atherosclerosis, and as a treatment during pregnancy.
Vitamin C	Citrus fruits, cantaloupe, strawberries, asparagus, broccoli, dark green leafy vegetables, cabbage, cauliflower, brussel sprouts, peppers, sweet potatoes and tomatoes	Vitamin C acts as an antioxidant, immune stimulant, antiviral and detoxifiers. It aids tissue synthesis and repair. High intake has been associated with cancer prevention and treatment of immune deficiencies. Some nutritionists recommend between 500 and 1000 mg. daily.

Vitamin	Food Sources	Considerations
Vitamin D	Fortified milk products, cereals, liver and fatty fishes and sun exposure.	Inadequate Vitamin D is associated with certain cancers. Vitamin D is necessary for calcium absorption, therefore it plays a part in preventing osteoporosis. Supplementation of 300-400 IU has been recommended if food sources are inadequate. Higher doses may cause side effects.
Vitamin E	Grain cereals, wheat germ, dark leafy vegetables, liver, walnuts, almonds, peanuts and vegetable oils.	Vitamin E has been shown to be beneficial as an antioxidant, in the treatment of menstrual cramps, PMS and fibrocystic breasts. It has been shown to be beneficial in the treatment of hot flashes and symptoms associated with menopause. 400 IU has been suggested as a safe daily supplement.
Calcium	Dairy products, dark green leafy vegetables, soybean products, canned salmon and sardines with bones, shrimp, figs, rhubarb	Calcium is essential for bone health and the prevention of osteoporosis in women. It is also necessary for heart health, nerve transmission and muscle contraction. Many nutritionists recommend that women supplement their intake with 1,000 to 1,500 mg. daily. Calcium carbonate or calcium citrate are more readily absorbed but should be taken with food to avoid stomach upset.
Iron	Red meats, chicken, fish, liver, spinach, green leafy vegetables, kidney and pinto beans.	Iron deficiency may occur in young women due to blood loss during menstruation. Pregnant women need more iron. Postmenopausal women rarely need supplementation. In general, iron supplements should be used only in conditions of anemia or iron deprivation. <i>Excessive iron may result in a compromise of the immune systems and coronary artery disease.</i>
Selenium	Fish, wheat products, grains, asparagus, mushrooms, garlic	Selenium has been found to play a role in cancer prevention, especially breast cancer. 100 to 200 mcg has been recommended as a safe supplemental dose.

One option for women is to take one multivitamin and mineral supplement with adequate dosages of vitamins A, C, E and B vitamins, adding only a calcium supplement. Folic acid and Iron may be considered during pregnancy.

Practicing Self Esteem

A positive self evaluation is a key component to mental health. Women should examine how they view themselves, replacing negative labels with positive ones.

- Negative Approaches:
 - *perfectionism*: you see yourself as a failure if your performance falls short of perfection. You put off decisions and tasks to avoid the possibility of a less than perfect outcome
 - *negative thinking*: you ignore your accomplishments and dwell on your faults or failures
 - *negative assumptions*: without real evidence, you assume that people are critical of you
 - *generalizing*: a single failure becomes a symbol of general failure and incompetence. You attribute failures to your personal flaws

- *pessimism*: you assume that the worst will happen and don't consider possible positive outcomes
- Positive Approaches:
 - *tolerance*: you accept that some of your abilities are stronger than others and your performance might not be perfect every day or on every task. You have realistic expectations of yourself and others.
 - *positive thinking*: you concentrate on your achievements and successes and look for supportive and nurturing personal contacts
 - *positive assumptions*: you assume that you are competent and accepted. If you do receive criticism, you use it constructively to improve yourself
 - *focusing*: you apply criticism to the specific task or experience being addressed, not to yourself as a person.
 - *optimism*: you are hopeful about your ability to meet challenges. You think about the gratification you will get from a positive outcome, such as doing a job well.

Self Help Tips for Improving Sleep

- go to bed and get up at the same time every day: doing so can help program your body's biological clock
- set aside enough hours for sleep each day
- limit naps. A short nap at the same time each day can be refreshing, but you should allow that much less time for sleep at night
- make your bedroom comfortable for sleeping. Do not use it for other activities such as watching t.v., eating, reading or finishing work
- wind down before you go to bed. Do some relaxation exercises, listen to soft music or read a good book – whatever you find relaxing
- do not drink alcohol late in the evening. Even one drink can make you sleep less soundly
- avoid caffeinated beverages and nicotine, which act as stimulants, before going to bed
- don't go to bed hungry or on a full stomach. A light carbohydrate snack before bedtime can help you sleep.
- avoid over the counter sleeping pills. They do not help over the long term and may contribute to other problems . . . get professional help if the above tips don't help.

Dealing With Anger

Anger has been implicated in a variety of women's health problems including depression, high blood pressure, breast cancer, heart disease, arthritis, stress, drug and alcohol abuse and obesity. Extreme anger signals a threat or state of emergency to the body and illness results. Women need to understand and address feelings of anger as they occur.

- *Reflect on the triggers that create anger.*
- *Instead of letting problems fester, address the anger causing problems right away.*
- *Keep an anger diary.* Become an expert on your own anger. . . learn what triggers it and how you reacted. Look at how you were feeling before the event, see if any patterns emerge. Keeping a diary demystifies anger and allows you to come up with other approaches.
- *Count to 10, or 20:* and then use a technique that experts call reflective coping, trying to solve the underlying problem or source of the anger.
- *Sweat it out:* vigorous exercise is an excellent outlet for powerful emotions
- *Cut your losses:* if there's no possibility of effecting a change then remove yourself from the anger provoking situation.

Mental Health Resources for Women

Mental health disorders sadly still carry with them a label of shame for many women who suffer from them. They are somehow perceived as a weakness or failure in a way that a case of the flu is not. Many of these disorders are easily treatable and curable with the proper education and treatment. Resources available to women include the many community support networks and healthlines. In addition the following services provide referrals and information to health care providers and individuals in need.

National Foundation for Depressive Illness

800.248.4344

information and physician referral

National Mental Health Association

800.969.6642

written information and referrals

Panic Disorder Information Hotline

800.64.PANIC

educational materials and referral

PMS Access

800.422.4767

information, literature, referrals

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COURSE EXAMINATION

PLEASE READ THE FOLLOWING INSTRUCTIONS BEFORE STARTING THE EXAM.

Transfer your answers to the detached answer sheet inserted with your course packet. Return the completed detached answer sheet/course evaluation to:

GSC Home Study
2335 American River Drive
Suite 406
Sacramento, CA 95825-7065

1. Women have an almost twofold risk of depression over men.
 - a. True
 - b. False
2. When evaluating a woman's mental health, the practitioner should assess:
 - a. Menstrual history
 - b. Diet
 - c. Over-the-counter medication use
 - d. All of the above
3. A woman's socioeconomic status is NOT a factor in her mental health profile.
 - a. True
 - b. False
4. A history of periods of elation and hyperactivity alternating with periods of depression is consistent with a diagnosis of:
 - a. Depression
 - b. Seasonal Affective Disorder
 - c. Bipolar Disorder
 - d. Anxiety Disorder
5. The treatment of choice for Manic Depressive Illness is:
 - a. Antidepressants
 - b. Psychotherapy
 - c. Daily light therapy
 - d. Lithium

6. Hyperthyroidism, epilepsy, and heartbeat abnormalities are most likely to be confused with:
 - a. Depression
 - b. Panic Disorder
 - c. Post Traumatic Stress Disorder
 - d. Phobias
7. Narcolepsy is characterized by:
 - a. Excessive daytime sleepiness
 - b. Inability to sleep for more than 5 hours a night
 - c. Night time seizure activity
 - d. All of the above
8. Schizophrenia generally requires long term intervention involving the use of antipsychotic medications.
 - a. True
 - b. False
9. Cognitive Behavior Therapy assists an individual in identifying and replacing negative thought patterns and behaviors.
 - a. True
 - b. False
10. Drugs which are frequently dangerous when used in combination with antidepressants include:
 - a. Anticholinergics
 - b. Antiarrhythmics
 - c. Antihypertensives
 - d. NSAIDs (nonsteroidal antiinflammatory drugs)
11. A diagnosis of depression depends on:
 - a. A six month period of depressed mood
 - b. A two month period of depressed mood
 - c. A two week period of depressed mood
 - d. No history of depressed mood
12. The biologic theory of depression suggests that:
 - a. The neurotransmitters norepinephrine and serotonin are deficient
 - b. Circulation to the brain is compromised
 - c. There is active neuron degeneration
 - d. All of the above
13. Antidepressant drug therapy is helpful in over half of the cases of depression.
 - a. True
 - b. False
14. The first choice of drug treatment for patients with depression is:
 - a. Monoamine oxidase inhibitors
 - b. Selective serotonin reuptake inhibitors
 - c. Tricyclic antidepressants
 - d. Atypical antidepressants

15. Women are more likely than men to attempt suicide.
 - a. True
 - b. False
16. Premenstrual syndrome is characterized by symptoms which:
 - a. Occur 7 to 14 days prior to menstruation
 - b. Subside shortly after the onset of menstruation
 - c. Subside after menopause
 - d. All of the above
17. Risk factors associated with Premenstrual Syndrome include family history, oral contraceptive use and a history of postpartum depression:
 - a. True
 - b. False
18. Women with PMS and women on hormone replacement therapy may require fewer B vitamins:
 - a. True
 - b. False
19. Anger can contribute to the incidence in women of breast cancer, hypertension and depression:
 - a. True
 - b. False
20. Exercise is an important component of a mental health program because:
 - a. It stimulates the release of endorphins such as serotonin
 - b. It fosters a positive self image
 - c. It provides a physical outlet for emotions
 - d. All of the above

